STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495113	A. BUILDING _____ B. WING _____	C 10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIRAM W DAVIS MEDICAL CTR	26317 WEST WASHINGTON STREET PETERSBURG, VA 23803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 10/15/19 through 10/16/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. The census in this 90 certified bed facility was 48 at the time of the survey. The survey sample consisted of 5 resident reviews.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on facility documentation and clinical record review and in the course of a complaint investigation, the facility staff failed to follow standards of quality for one resident (#2) in a survey sample of 5 Residents. Resident #2 was not served the correct meal tray which had food specifically prepared to meet his medical needs. The findings included: Resident #2 a 58 year old man was admitted to the facility on 5/28/15 with diagnoses of but not limited to dysphagia, history of recurrent aspiration pneumonia, seizure disorder, schizophrenia, hypothermia, bradycardia, spinal stenosis, DJD (Degenerative Joint Disease) to cervical spine (neck), g-tube and conduct	F 658	1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** The Certified Nurse Assistant with the deficient practice was educated on October 4, 2019 on following the meal card; ensuring the resident is given the correct meal tray listed on the Comprehensive Care Plan. 2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents have the potential to be at risk for not being served the correct meal tray. 3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** All direct care staff will be in-serviced regarding following the meal card; ensuring the resident is given the correct meal tray listed on the Comprehensive Care Plan.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Facility Director/CEO — 11/06/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 658	Continued From page 1 disorder unspecified. Resident #2's most recent MDS (minimum data set) with ARD (assessment reference date) of 7/25/19 coded as an annual assessment, codes the Resident as having a (Brief Interview of Mental Status) BIMS score of 0, indicating the Resident is unwilling or unable to complete. The Resident was coded as (#4) Total dependence requiring (#3) 2+ person physical assistance for toileting. Bathing, dressing and transfers. For ambulation via wheel chair and for eating he is coded as (#3) Extensive Assistance and requiring (#2) 1 person physical assistance. On 10/15/19 during clinical record review it was discovered that on 10/4/19 the Resident had received a meal tray with a regular diet when he has orders for chopped diet with thickened liquids. The resident subsequently choked and had to have the Heimlich maneuver performed on him. Excerpts from the FRI (facility reported incident) read: "Results of the investigation showed that the resident received a regular diet that staff cut up into pieces, instead of the chopped diet that was ordered. The facility kitchen sent the correct diet for that meal, but the staff assisting the resident with that meal admitted to mistakenly giving the resident a regular diet tray instead." On 10/16/19 at approximately 10:00 AM the DON provided a copy of a document titled "Clinical Procedure 152-A Resident / Patient dining." Excerpts from the document state:	F 658	4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** A meal observation tool will be implemented to ensure staff compliance with following the meal card; ensuring the resident is given the correct meal tray listed on the Comprehensive Care plan. 5. **Include dates when the corrective action will be completed.** November 30, 2019	

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F 658	Continued From page 2 "IV- 1. Dining Each resident/patient will have an individualized meal card. a) Staff making sure they are following the instructions on the resident's meal card b) Ensuring residents are given the correct diet c) Double checking the meal tickets against the meal cards prior to serving the residents and not modifying any diet." 2. All staff will follow the "Five Rights" of meal service assistance: *Right Resident *Right Diet *Right Consistency including not modifying food texture *Right Level of Supervision or Assistance *Right Equipment to Include Adaptive Equipment and Dentures. The employee received an "Employee Counseling Report" that read: "Reason for conference: On 10/4/19, you inadvertently gave a patient the incorrect tray. This lack of oversight is potentially detrimental to the patient's wellbeing, as in addition to choking, consuming the incorrect meal consistency can be fatal to the patient." "Corrective actions to be taken by employee: When offering nutrition to patients please review meal card to ensure the correct diet consistency and precautions are being followed. Additionally double check the meal tickets against the meal card before offering the meal to the patient. If there are any concerns, please report to the nurse and or speech therapist for follow up."	F 658		

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F 658	Continued From page 3 "Employee Comments: "I not double checking I mistakenly gave the wrong tray which resulted in the incident which I very sorry for [sic]. I've been re-in serviced and am aware of protocol." On 10/16/19 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation and clinical record review and in the course of a complaint investigation, the facility staff failed to ensure the Residents are free from accident and hazarads for 1 Resident (#2) was free from accident hazards. Findings included: For Resident #2 the facility staff accidentally gave the Resident the wrong tray which resulted in a choking incident requiring the Heimlich maneuver. Resident #2 a 58 year old man was admitted to the facility on 5/28/15 with diagnoses of but not limited to dysphagia, history of recurrent	F 689	1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** The Certified Nursing Assistant with the deficient practice was educated on October 4, 2019 on not modifying a regular tray to chopped to prevent accidents. 2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents have the potential to be at risk for accidents from altering meal trays. 3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** All direct care staff will be in-serviced on not modifying any diet to prevent accidents. 4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** A meal observation tool will be implemented to ensure staff compliance with not modifying any diet to prevent accidents.	

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F 689	Continued From page 4	F 689	5. Include dates when the corrective action will be completed. November 30, 2019	

aspiration pneumonia, seizure disorder, schizophrenia, hypothermia, bradycardia, spinal stenosis, DJD (Degenerative Joint Disease) to cervical spine (neck), g-tube and conduct disorder unspecified.

Resident #2's most recent MDS (minimum data set) with ARD (assessment reference date) of 7/25/19 coded as an annual assessment, codes the Resident as having a (Brief Interview of Mental Status) BIMS score of 0, indicating the Resident is unwilling or unable to complete. The Resident was coded as (#4) Total dependence requiring (#3) 2+ person physical assistance for toileting. Bathing, dressing and transfers. For ambulation via wheel chair and for eating he is coded as (#3) Extensive Assistance and requiring (#2) 1 person physical assistance.

On 10/15/19 during clinical record review it was discovered that on 10/4/19 the Resident had received a meal tray with a regular diet when he has orders for chopped diet with thickened liquids. The resident subsequently choked and had to have the Heimlich maneuver performed on him.

Excerpts from the FRI (facility reported incident) read:

"Results of the investigation showed that the resident received a regular diet that staff cut up into pieces, instead of the chopped diet that was ordered. The facility kitchen sent the correct diet for that meal, but the staff assisting the resident with that meal admitted to mistakenly giving the resident a regular diet tray instead."

On 10/15/19 at approximately 4:00 PM an

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F 689	Continued From page 5	F 689		

interview was conducted with employee G (Dietary Manager) who stated that in the kitchen they have a double check system for the meal trays. The tickets are on the tray the food gets placed on the tray according to the tickets and "We have kitchen supervisors who do nothing but check the trays as they come off the line to see that the meal is correct."

When asked about the chopped diet he stated that in a chopped diet the food is cut 1/2" X 1/2" cubes, the ground diet is 1/4" X 1/4" cubes.

On 10/16/19 at approximately 3:00 PM in an interview with employee F (Speech Language Pathologist) she stated that she was on the floor the day of the incident and remembers the Resident got an alternate tray instead of his chopped diet try by accident. She further elaborated that when she found out what was going on she looked at the tray and "I realized the problem right away because I was feeding someone with a chopped diet and it was chopped beef patty with gravy and [Resident #2] had a grilled chicken sandwich cut up on his tray."

Employee F stated that a chopped diet from the kitchen is cut up to specific size pieces. With the staff cutting the food there was no way to tell what size the pieces were. She also stated that the kitchen tends to send food that is moister or has gravy or sauce to keep it from drying out. The chicken sandwich was grilled chicken on a bun with lettuce and tomato.

On 10/16/19 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.